DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

MAY 15 2012

Ms. Patricia Casanova, Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204

RE: TN 11-022

Dear Ms. Casanova:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-022. Effective for services on or after July 1, 2011, this amendment proposes revisions to inpatient hospital reimbursement methodologies. Specifically, this amendment eliminates a 5% rate reduction; implements a hospital adjustment factor; and provides for disproportionate share hospital (DSH) payment redistribution methodology. Additionally, for the period of July 1, 2011 through June 30, 2013, this amendment eliminates the following: an add-on for hospitals that deliver hospital care for the indigent; supplemental payments for safety-net hospitals; limitations on payments for an individual claim to the lesser of the amount computed or billed charges; payment adjustment for municipal hospitals; supplemental payments to private hospitals; outlier payments for high volume.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 11-022 is approved effective July 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (608) 441-5344.

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-022

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902 (a)(13)(A), 1923 of the Social Security Act
42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $8,150 Thousands
b. FFY 2012 $33,450 Thousands

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A page 1H.3
Attachment 4.19A page 6.1(a)
Attachment 4.19A page 6.1(b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19A page 1H.3
Attachment 4.19A page 6.1(a)

10. SUBJECT OF AMENDMENT:
This SPA makes changes to the State Plan as a result of changes made to Indiana State Law by House Enrolled Act (HEA) 1001 (2011), including the implementation of an assessment fee on most hospitals, the revision of the reimbursement methodology for inpatient hospitals. The fees imposed will be utilized to cover the non-federal share of DSH payments as well as to increase Medicaid payment rates to the aggregate level of reimbursement that would be paid under Medicare payment principles.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE C [redacted]

13. TYPED NAME: Patricia Casanova

14. TITLE: Director of Medicaid

15. DATE SUBMITTED: 9-30-11

16. RETURN TO:
Patricia Casanova
Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Audie Gilmer, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 16 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2011

20. SIG [redacted] OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

The rates paid to providers in accordance with methods described in the preceding pages of Attachment 4.19-A for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 5% reduction for services on and after January 1, 2010. The 5% rate reduction will remain in effect through June 30, 2011 and will be replaced by a hospital adjustment factor.

For the period of July 1, 2011 through June 30, 2013, Indiana Hospital rates are subject to a hospital adjustment factor. The hospital adjustment factors will result in aggregate payments that reasonably approximate the upper payment limits but do not result in payments in excess of the upper payment limits.

A test will be made following the close of each state fiscal year to assure that annual inpatient payments do not exceed total inpatient billed charges for the fiscal year. Payments in excess of billed charges will be recovered. As permitted by 42 CFR 447.271(b), nominal charge hospitals identified in IC 12-15-15-11 are not subject to the inpatient charge limitation above.

The initial hospital adjustment factor for the DRG Base rate is 3.00.
The initial hospital adjustment factor for Psych Level of Care rates is 2.20.
The initial hospital adjustment factor for acute care hospital Rehab Level of Care rates is 3.00.
The initial hospital adjustment factor for Burn Level of Care rates is 1.00.

The adjustment factors above apply to acute care hospitals licensed under IC 16-21, except for those specified below, and psychiatric institutions licensed under IC 12-25.

The hospital adjustment factor is 0.95 for:

- Long term care hospitals
- Out-of-state hospitals
- Freestanding Rehabilitation hospitals.

The following sections of the State Plan do not apply for the period of July 1, 2011 through June 30, 2013:

- Limitations on payments for an individual claim to the lesser of the amount computed or billed charges.
- Medicaid Inpatient Payments for Safety net Hospitals
- Medicaid Hospital Reimbursement Add-On Payment Methodology to Compensate Hospitals that Deliver Hospital Care for the Indigent Program Service.
- Municipal Hospital Payment Adjustments
- Supplemental Payments to Privately-Owned Hospitals.
- High Volume Outlier Payment Adjustment

The agency's rates are published in provider bulletins which are accessible through the agency's website, www.indianamedicaid.com.

III. PAYMENT ADJUSTMENTS

A. Inpatient Disproportionate Share Payment Adjustment

Disproportionate Share Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment calculated in the following manner for SFY 2012 and SFY 2013:

In no instance will any Disproportionate Share Hospital payments exceed the hospital specific limit as defined in subsection B 1. The provisions in subsection B 1 are applicable for SFY 2012 and SFY 2013 and also apply to DSH eligible freestanding psychiatric institutions licensed under IC 12-25. DSH payments that are retrospectively determined to exceed the hospital specific limit shall be recovered by the office. For DSH payments made on or after 7/1/2011, any DSH allotment recovered by the office may be redistributed to other DSH eligible hospitals in accordance with the payment order below, not to exceed any hospital's hospital specific limit. The amount of DSH redistribution payments is limited to the amount recouped by the office.

Any Disproportionate Share Hospital may decline all or part of the annual DSH payments by submitting documentation to the State indicating that it declines the DSH payments and the amount of DSH payments being declined.

- Step One: Each Disproportionate Share Hospital receives a payment of $1,000, not to exceed the hospital's hospital specific limit.

- Step Two: Municipal Disproportionate Share Providers established and operated under Indiana Code 16-22-2 or 16-23 receive payment amounts equal to the lower of the hospital's hospital specific limit for the payment year less any Step One amount received by that hospital; or the hospital's net 2009 supplemental payment amount.

- Step Three: DSH eligible acute care hospitals licensed under IC 16-21 located in Lake County, Indiana receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any Step One amount received by that hospital.

- Step Four: DSH eligible private acute care hospitals licensed under IC 16-21 and DSH eligible hospitals established and operated under Indiana Code 16-22-8 receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any payment received by that hospital under step one. If not enough DSH funds are available to pay all eligible hospitals in this group up to their respective hospital specific limits, the amount paid to each hospital will be reduced by the same percentage for all hospitals in the group.

- Step Five: If there is DSH remaining after the above steps, DSH eligible freestanding psychiatric institutions licensed under IC 12-25 receive payment amounts equal to the institution's hospital specific limit for the payment year, less any payment received by the institution under step one. If not enough DSH funds are available to pay all eligible institutions in this group up to their respective hospital specific limits, the amount paid to each institution will be reduced by the same percentage for all institutions in the group. Institutions owned by the State of Indiana are not eligible for payments from this pool.

Disproportionate share hospital payments described in this section may be made on an interim basis throughout the year as determined by the office.

Interim DSH payments will be calculated using the payment methodology described above, based on the best available data at the time of the calculation. To determine the interim payment amount, the hospitals' calculated DSH payments will be multiplied by two percentages: 1) the ratio of the total DSH allotment for the payment year divided by the sum of all DSH eligible and appealing hospitals' estimated hospital specific limits for that same year, not to exceed 1, and 2) the percentage of the state fiscal year that has been completed at the time of the payment. Partial payments to psychiatric hospitals will be limited to the amount paid in step 1.

The disproportionate share payment adjustment calculations described below and in subsections B 2 and C through G do not apply for SFY 2012 and SFY 2013.

(1) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars ($2,000,000) shall be distributed to all qualified private psychiatric DSH's licensed by the director of the state department of health to provide private institutional psychiatric care, whose Medicaid impatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana and/or whose low income utilization rate exceeds twenty-five percent (25%). The funds in this pool must be distributed to the qualifying hospitals in the proportion that each qualifying hospital's Medicaid inpatient utilization rate bears to the total of the Medicaid inpatient utilization rates of all hospitals in the pool as determined based on data form the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital. In no instance will any hospital in this pool be entitled to disproportionate share amounts that when added to the hospital's payments associated with Medicaid and uninsured care yield a combined total reimbursement that exceeds 100% of the hospital's allowable cost of delivering Medicaid and uninsured care. DSH payments that are retrospectively determined to exceed this cap of 100% of allowable cost shall be recovered by the office.

(2) For each state fiscal year ending on or after June 30, 1995, a pool not exceeding one hundred ninety-one million dollars ($191,000,000) shall be distributed to all state mental health DSH's whose inpatient utilization rates are al least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana or whose low income utilization rate exceeds twenty-five percent (25%). The fund in this pool must be distributed to the qualifying hospitals in the proportion that each hospital's low income utilization rate, multiplied by total Medicaid days, bears to the product of the same factors of all hospital in the pool using data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital.

OS Notification

State/Title/Plan Number: Indiana 11-022

Type of Action: SPA Approval

Required Date for State Notification: May 21, 2012

Fiscal Impact:

FY 2011	$8,150,000
FY 2012	$33,450,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after July 1, 2011, this amendment proposes revisions to inpatient hospital reimbursement methodologies. Specifically, this amendment eliminates a 5% rate reduction; implements a hospital adjustment factor with the intent to bring aggregate payments more in line with the UPL; and provides for disproportionate share hospital (DSH) payment redistribution methodology. Additionally, for the period of July 1, 2011 through June 30, 2013, this amendment eliminates the following: an add-on for hospitals that deliver hospital care for the indigent; supplemental payments for safety-net hospitals; limitations on payments for an individual claim to the lesser of the amount computed or billed charges; payment adjustment for municipal hospitals; supplemental payments to private hospitals; outlier payments for high volume.

The State met public process requirements. Funding the non-Federal share comes from a new hospital provider tax. The State submitted a request for waiver of the broad-based and uniformity requirements which was reviewed and found to be acceptable by CO. There are no issues with the UPL.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact:

Todd McMillion (608) 441-5344
National Institutional Reimbursement Team